

**DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES**

**APPLICATION FOR CERTIFICATION TO PROVIDE LIMITED SERVICES  
TO AN INDIVIDUAL UNDER THE SELF-ADMINISTERED MODEL**

Name of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Name of Person Applicant Desires to Support: \_\_\_\_\_

Service(s) Applicant Desires to Provide (*Circle All Applicable Services*):      FS1      SLA      RP1      CH1      FTP

**Knowledge Requirements for Certification:**

Letter of Employment      Date \_\_\_\_\_

Department of Human Services  
Provider Code of Conduct      Date \_\_\_\_\_

Division of Services for People With  
Disabilities' (Division) Code of Conduct      Date \_\_\_\_\_

Division Human Rights Policy 1-1, Page 1      Date \_\_\_\_\_

Emergency Contact Information      Date \_\_\_\_\_

Person's Support Book      Date: \_\_\_\_\_

Behavior Management  
(Recommended, not required)      Date \_\_\_\_\_

**SIGNATURES:**

I represent that I have read and am familiar with the above-identified materials and that I have been oriented to and/or trained on all of the materials by: \_\_\_\_\_ on the dates indicated. I further represent that I both understand and will comply with the requirements identified in the materials in providing services to the Person and that I am capable of providing appropriate services to the Person.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

I, \_\_\_\_\_ represent that I am the Person, the Person's Representative, or the Person with a Designated Administrator of Supports for the Person and that I am familiar with both the above-identified materials and the supports required by the Person. I further represent that I provided orientation and/or training to the Applicant on all of the required materials on the dates indicated. I further represent that based on the training and orientation provided to the Applicant, I am satisfied the Applicant has the knowledge, understanding, and ability to provide appropriate services to the Person.

\_\_\_\_\_  
Signature of Person, Guardian, or Designated Administrator

\_\_\_\_\_  
Date

**AWARD OF CERTIFICATION TO PROVIDE LIMITED SERVICES  
TO AN INDIVIDUAL UNDER THE SELF-ADMINISTERED MODEL**

Based on the forgoing representations of the Applicant and the Person, Person's Legal Guardian, or Person's Designated Administrator of Supports, the Applicant has met the minimum requirements necessary for Certification to Provide Limited Services to an Individual Under the Self-Administered Model. The Division, therefore, awards the Applicant certification to provide the following services (*circle those applicable*):

FS1      SLA      RP1      CH1      FTP      to : \_\_\_\_\_.

(Name of Person)

\_\_\_\_\_  
Signature of Division Support Coordinator

\_\_\_\_\_  
Date